STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185352	A. BUILDING _____ B. WING _____	C 09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING AND REHABILITATION CENTER	**31 DERICKSON LANE STANTON, KY 40380**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey (complaints #KY23741, KY23765, and KY23792) was initiated on 09/01/15 and concluded on 09/03/15. KY23741 and KY23765 were unsubstantiated with no deficient practice identified. KY23792 was substantiated with deficient practice identified at a scope and severity of "D."	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		9/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/05/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review it was determined the facility failed to immediately notify the physician when there was an accident involving a resident for one (1) of three (3) sampled residents (Resident #28). Record review revealed Resident #28 sustained a fall on 06/12/15, at approximately 10:00 PM. The nurse faxed a report to the resident's physician on 06/12/15 to notify the physician of the fall; however, an interview with the resident's physician revealed he did not receive notification that the resident fell until 06/13/15 or 06/14/15.

The findings include:

Review of the facility's policy titled "Change in Condition Process," with a revision date of September 2013, revealed that to ensure the optimal outcome for the resident the nursing process of assessment, plan, intervention, and evaluation would be used. The policy also stated the physician's involvement would be required if it was in the judgment of the licensed professional nurse. The policy also revealed the physician should be notified with any fall for any orders for treatment.

Record review revealed the facility admitted Resident #28 on 07/01/12, with diagnoses that included Cerebral Vascular Accident and Left

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Sided Hemiplegia. Review of the Quarterly Minimum Data Set (MDS) assessment dated 05/18/15, revealed the facility assessed Resident #28 to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Further review of the MDS revealed Resident #28 required the extensive assistance of two (2) persons for bed mobility, transfers, and toileting. The MDS stated Resident #28 had functional limitations on one (1) side of his/her body in both the upper and lower extremities.

Review of a fall risk assessment for Resident #28 completed on 09/11/14, revealed Resident #28 scored a 15, which indicated the resident was at high risk for falls. Review of the resident's Care Plan, with a revision date of 04/30/15, revealed the facility assessed Resident #28 to be at risk for falls and interventions were in place to prevent falls. Further review of the Care Plan revealed Resident #28 was nonambulatory; required the assistance of two (2) persons for transfers; was to have an electric bed, which would go into a high or low position with locked wheels; and required Dycem (nonslip material) under the resident's mattress to prevent falls.

Review of a fall investigation, dated 06/14/15, revealed Resident #28 fell out of bed while attempting to turn over on 06/12/15, at approximately 10:00 PM. The investigation stated that Licensed Practical Nurse (LPN) #1 documented on the incident report that she had contacted Resident #28's physician after the fall. However, a written statement by LPN #1 revealed she had not called the physician, but had faxed the information to the physician's office. The investigation further revealed Registered Nurse

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(RN) #1 notified the physician on 06/13/15 at 3:45 PM.

Interview conducted with Resident #28 on 09/02/15 at 2:30 PM revealed he/she had fallen out from bed on 06/12/15. Resident #28 stated he/she had pain in the right arm after the fall, but told staff that he/she did not want to go to the hospital. The resident stated he/she slept during the night without problems, but was unable to feed himself/herself breakfast the next morning due to arm pain.

Attempts to contact LPN #1 on 09/02/15 at 3:00 PM and on 09/03/15 at 11:00 AM were unsuccessful.

Attempts to contact the former Director of Nursing (DON) on 09/02/15 at 3:05 PM and on 09/03/15 at 3:10 PM were also unsuccessful.

An interview with Resident #28's physician on 09/03/15 at 11:20 AM and 2:30 PM revealed he was not notified that Resident #28 fell until 06/13/15 or 06/14/15. He stated nursing staff should have notified him by phone.

Interview conducted with the Administrator on 09/03/15 at 11:30 AM revealed nurses were required to notify the physician, DON, and the Administrator whenever any resident experienced a fall in the facility. The Administrator stated Resident #28 had experienced a fall on a Friday night and faxing information regarding the resident's fall to the physician was unacceptable. The Administrator stated LPN #1 should have called the physician. Further interview with the Administrator revealed LPN #1 was terminated from employment for not following the facility's

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F 157	Continued From page 4 policy related to notification.	F 157		